

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0004721</u>		II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER																									
Facility Name: <u>GENESEO GOOD SAMARITAN VILLAGE</u>		I have examined the contents of the accompanying report to the State of Illinois, for the period from <u>1/1/02</u> to <u>12/31/02</u> and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.																									
Address: <u>704 S ILLINOIS ST</u> <u>GENESEO</u> <u>61254</u> Number City Zip Code		Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.																									
County: <u>HENRY</u>		Officer or Administrator of Provider (Signed) _____ <u>3/25/03</u> (Type or Print Name) <u>Raye Nae Nylander</u> (Date)																									
Telephone Number: <u>(309) 944-6424</u> Fax # <u>(309) 944-6605</u>		(Title) <u>VICE PRESIDENT</u>																									
IDPA ID Number: <u>45-0228055</u>		(Signed) _____ (Date)																									
Date of Initial License for Current Owners: <u>1/1/1970</u>		Paid Preparer (Print Name and Title) _____ (Firm Name & Address) _____ (Telephone) <u>()</u> Fax # ()																									
Type of Ownership: <table border="0"> <tr> <td><input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT</td> <td><input type="checkbox"/> PROPRIETARY</td> <td><input type="checkbox"/> GOVERNMENTAL</td> </tr> <tr> <td><input checked="" type="checkbox"/> Charitable Corp.</td> <td><input type="checkbox"/> Individual</td> <td><input type="checkbox"/> State</td> </tr> <tr> <td><input type="checkbox"/> Trust</td> <td><input type="checkbox"/> Partnership</td> <td><input type="checkbox"/> County</td> </tr> <tr> <td>IRS Exemption Code <u>501 (3)</u></td> <td><input type="checkbox"/> Corporation</td> <td><input type="checkbox"/> Other _____</td> </tr> <tr> <td></td> <td><input type="checkbox"/> "Sub-S" Corp.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Limited Liability Co.</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Trust</td> <td></td> </tr> <tr> <td></td> <td><input type="checkbox"/> Other _____</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL	<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State	<input type="checkbox"/> Trust	<input type="checkbox"/> Partnership	<input type="checkbox"/> County	IRS Exemption Code <u>501 (3)</u>	<input type="checkbox"/> Corporation	<input type="checkbox"/> Other _____		<input type="checkbox"/> "Sub-S" Corp.			<input type="checkbox"/> Limited Liability Co.			<input type="checkbox"/> Trust			<input type="checkbox"/> Other _____		MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630	
<input checked="" type="checkbox"/> VOLUNTARY, NON-PROFIT	<input type="checkbox"/> PROPRIETARY	<input type="checkbox"/> GOVERNMENTAL																									
<input checked="" type="checkbox"/> Charitable Corp.	<input type="checkbox"/> Individual	<input type="checkbox"/> State																									
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	<input type="checkbox"/> Limited Liability Co.																										
	<input type="checkbox"/> Trust																										
	<input type="checkbox"/> Other _____																										
In the event there are further questions about this report, please contact: Name: <u>ALETA CARLSON</u> Telephone Number: <u>(605) 362-3843</u>																											

STATE OF ILLINOIS

Page 2

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721 Report Period Beginning: 1/1/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>72</u>	Skilled (SNF)	<u>72</u>	<u>26,280</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>72</u>	TOTALS	<u>72</u>	<u>26,280</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>7,190</u>	<u>17,685</u>	<u>928</u>	<u>25,803</u>	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>7,190</u>	<u>17,685</u>	<u>928</u>	<u>25,803</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4.) 98.18%

D. How many bed-hold days during this year were paid by Public Aid?

128 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)Outpatient Therapy

F. Does the facility maintain a daily midnight census?

YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☒ NO ☐

I. On what date did you start providing long term care at this location?

Date started 1/1/1971

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date _____ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number
of beds certified 72 and days of care provided _____Medicare Intermediary CAHABA

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	178,708	12,315	6,227	197,250		197,250		197,250			1
2	Food Purchase		136,112		136,112		136,112	(1,439)	134,673			2
3	Housekeeping	85,937	19,130		105,067		105,067		105,067			3
4	Laundry	66,015	14,396		80,411		80,411		80,411			4
5	Heat and Other Utilities			57,984	57,984		57,984	(534)	57,450			5
6	Maintenance	66,743	9,681	65,220	141,644		141,644	1,565	143,209			6
7	Other (specify):*			4,235	4,235		4,235		4,235			7
8	TOTAL General Services	397,403	191,634	133,666	722,703		722,703	(408)	722,295			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	1,066,512	72,820	1,776	1,141,108	(6,630)	1,134,478	(23,413)	1,111,064			10
10a	Therapy	60,190	619	59,419	120,228		120,228	(46,000)	74,228			10a
11	Activities	59,451	9,285	4,763	73,499		73,499	(120)	73,379			11
12	Social Services	37,347	32	1,635	39,014		39,014		39,014			12
13	Nurse Aide Training					6,630	6,630		6,630			13
14	Program Transportation			1,875	1,875	898	2,773		2,773			14
15	Other (specify):*	31,728			31,728		31,728		31,728			15
16	TOTAL Health Care and Programs	1,255,228	82,756	69,468	1,407,452	898	1,408,350	(69,533)	1,338,816			16
	C. General Administration											
17	Administrative	45,256		122,014	167,270		167,270	17,205	184,475			17
18	Directors Fees											18
19	Professional Services			6,211	6,211		6,211		6,211			19
20	Dues, Fees, Subscriptions & Promotions			22,076	22,076		22,076	(22,148)	(72)			20
21	Clerical & General Office Expenses	54,179	17,705	31,005	102,889		102,889	(9,524)	93,365			21
22	Employee Benefits & Payroll Taxes			361,417	361,417		361,417	33,724	395,141			22
23	Inservice Training & Education			15,508	15,508		15,508	(971)	14,537			23
24	Travel and Seminar			2,533	2,533	(898)	1,635	(38)	1,597			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			36,646	36,646		36,646	(104)	36,542			26
27	Other (specify):*	21,783		5,385	27,168		27,168	(21,998)	5,170			27
28	TOTAL General Administration	121,218	17,705	602,795	741,718	(898)	740,820	(3,854)	736,966			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,773,849	292,095	805,929	2,871,873		2,871,873	(73,795)	2,798,077			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE #0004721 Report Period Beginning: 1/1/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	D. Ownership											
30	Depreciation			165,188	165,188		165,188	(13,603)	151,585			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			4,220	4,220		4,220		4,220			35
36	Other (specify):*											36
37	TOTAL Ownership			169,408	169,408		169,408	(13,603)	155,805			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			39,339	39,339		39,339		39,339			42
43	Other (specify):*			2,409	2,409		2,409	(2,409)				43
44	TOTAL Special Cost Centers			41,748	41,748		41,748	(2,409)	39,339			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,773,849	292,095	1,017,085	3,083,029		3,083,029	(89,807)	2,993,221			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE**# **0004721**Report Period Beginning: **1/1/02**Ending: **12/31/02****VI. ADJUSTMENT DETAIL****A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.****In column 2 below, reference the line on which the particular cost was included. (See instructions.)**

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,439)	2		4
5	Telephone, TV & Radio in Resident Rooms	(534)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(1,440)	6		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(22,148)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(117,344)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (142,905)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 53,098		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (89,807)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

STATE OF ILLINOIS
GENESEO GOOD SAMARITAN VILLAGE

Page 5A

ID# 0004721
Report Period Beginning: 1/1/02
Ending: 12/31/02

NON-ALLOWABLE EXPENSES		Amount	Sch. V Line Reference	
1	Uniform Inc	\$ (1,663)	21	1
2	Administration	(89)	21	2
3	Uncl Payroll checks	(70)	21	3
4	Postage	(23)	21	4
5	Activity	(120)	11	5
6	Glucose Strip Exp	(6,382)	10	6
7	ProClaim Offset	(1,000)	10	7
8				8
9	Deferred Maint Costs - 2000/2001	1,117	6	9
10	Depreciation Exp - Apt and Duplex	(12,056)	30	10
11	Deferred Maint Costs - 1996-1999	1,888	6	11
12	Depreciation Exp - Admin House	(1,547)	30	12
13				13
14	Penalty Fee	(366)	21	14
15				15
16	Prescr Drugs - Reimb	(16,031)	10	16
17	Salaries - Res Dev	(19,526)	27	17
18	Vac Acc - Res Dev	978	27	18
19	FICA - Res Dev	(2,315)	22	19
20	Supplies - Res Dev	(1,706)	21	20
21	Sm Equip - Res Dev	(437)	21	21
22	Misc Fdraisers Exp	(5,170)	21	22
23	Travel - Res Dev	(38)	24	23
24	Staff Dev - Res Dev	(971)	23	24
25	Salaries - Marketing	(3,235)	27	25
26	P/Serv-Laboratory-MDCR	(2,409)	43	26
27	Therapy Offset - PT, OT, ST	(46,000)	10A	27
28				28
29				29
30	Newsletters - Res Dev	(215)	27	30
31	Staff Pension - Res Dev	42	22	31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(117,344)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721

Report Period Beginning:

1/1/02

Ending:

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,439)	0	0	0	0	0	0	0	0	0	0	(1,439)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(534)	0	0	0	0	0	0	0	0	0	0	(534)	5
6	Maintenance	1,565	0	0	0	0	0	0	0	0	0	0	1,565	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(408)	0	0	0	0	0	0	0	0	0	0	(408)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(23,413)	0	0	0	0	0	0	0	0	0	0	(23,413)	10
10a	Therapy	(46,000)	0	0	0	0	0	0	0	0	0	0	(46,000)	10a
11	Activities	(120)	0	0	0	0	0	0	0	0	0	0	(120)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(69,533)	0	0	0	0	0	0	0	0	0	0	(69,533)	16
	C. General Administration													
17	Administrative	0	17,205	0	0	0	0	0	0	0	0	0	17,205	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(22,148)	0	0	0	0	0	0	0	0	0	0	(22,148)	20
21	Clerical & General Office Expenses	(9,524)	0	0	0	0	0	0	0	0	0	0	(9,524)	21
22	Employee Benefits & Payroll Taxes	(2,273)	35,997	0	0	0	0	0	0	0	0	0	33,724	22
23	Inservice Training & Education	(971)	0	0	0	0	0	0	0	0	0	0	(971)	23
24	Travel and Seminar	(38)	0	0	0	0	0	0	0	0	0	0	(38)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	(104)	0	0	0	0	0	0	0	0	0	(104)	26
27	Other (specify):*	(21,998)	0	0	0	0	0	0	0	0	0	0	(21,998)	27
28	TOTAL General Administration	(56,952)	53,098	0	0	0	0	0	0	0	0	0	(3,854)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(126,893)	53,098	0	0	0	0	0	0	0	0	0	(73,795)	29

Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
1	V	17 Admin Acctg	\$ 122,014		100.00%	\$ 139,219	\$ 17,205 1
2	V	22 Workers Comp	41,676			50,428	8,752 2
3	V	22 Unemploy Charges Paid	(2)				2 3
4	V	26 Insurance	36,646			36,542	(104) 4
5	V	22 Group Health	144,557			171,800	27,243 5
6	V						6
7	V						7
8	V						8
9	V						9
10	V						10
11	V						11
12	V						12
13	V						13
14	Total		\$ 344,891			\$ 397,989	\$ * 53,098 14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5	NOT APPLICABLE										5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721 Report Period Beginning: 1/1/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization The EV Lutheran Good Samaritan Society
 Street Address 4800 W 57th St PO Box 5038
 City / State / Zip Code Sioux Falls, SD 57117-5038
 Phone Number (605) 362-3100
 Fax Number (605) 362-3265

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See under separate cover the				\$	\$		\$	1
2	Report on Allowable Central								2
3	Office Expenses for the Year								3
4	ended December 31, 2002								4
5									5
6	* The allocated expenses in this report related directly to each centers								6
7	Nursing home facility and no additional re-allocation of these expenses								7
8	between healthcare facilities and non healthcare facilities/apartments								8
9	should be necessary								9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Not Applicable						\$	\$			\$	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6												6	
7												7	
8												8	
9	TOTAL Facility Related						\$	\$			\$	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$	\$			\$	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

13	FROM R. E. TAX STATEMENT FOR 2001	\$	13
14	PLUS APPEAL COST FROM LINE 5	\$	14
15	LESS REFUND FROM LINE 6	\$	15
16	AMOUNT TO USE FOR RATE CALCULATION	\$	16

1. Please indicate a negative number by use of brackets (). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GENESEO GOOD SAMARITAN VILLAGE COUNTY HENRY

FACILITY IDPH LICENSE NUMBER 0004721

CONTACT PERSON REGARDING THIS REPORT _____

TELEPHONE () FAX #: ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1.	_____	_____	\$ _____	\$ _____
2.	_____	_____	\$ _____	\$ _____
3.	_____	_____	\$ _____	\$ _____
4.	_____	_____	\$ _____	\$ _____
5.	_____	_____	\$ _____	\$ _____
6.	_____	_____	\$ _____	\$ _____
7.	_____	_____	\$ _____	\$ _____
8.	_____	_____	\$ _____	\$ _____
9.	_____	_____	\$ _____	\$ _____
10.	_____	_____	\$ _____	\$ _____
		TOTALS	\$ _____	\$ _____

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

A. Square Feet:
 22,848

B. General Construction Type:
 Exterior
 Brick
 Frame
 Number of Stories

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.)
 List entity name, type of business, square footage, and number of beds/units available (where applicable).
 APARTMENTS - 8 UNITS
 DUPLEXES - 17 UNITS

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES
 ☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1			1969	\$ 26,000	1
2					2
3	TOTALS			\$ 26,000	3

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE

0004721

Report Period Beginning:

1/1/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72		1971	1971	\$ 494,740	\$ 12,369	40	\$ 12,369	\$	\$ 392,700	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	BUILDING			1977	1,100		VARIES			1,100	10
11				1978	7,629		20			7,629	11
12				1981	169,320	5,451	VARIES	5,451		122,983	12
13				1982	2,299	27	VARIES	27		2,299	13
14				1986	3,335	15	VARIES	15		3,289	14
15				1987	15,313	520	VARIES	520		12,972	15
16				1988	132,771	5,313	VARIES	5,313		102,924	16
17				1989	32,054	977	VARIES	977		28,358	17
18				1990	147,305	5,489	VARIES	5,489		108,771	18
19				1991	5,106	53	VARIES	53		4,904	19
20				1992	99,897	2,024	VARIES	2,024		90,909	20
21				1993	80,357	4,864	VARIES	4,864		49,578	21
22				1994	73,192	4,491	VARIES	4,491		44,416	22
23				1995	76,365	4,715	VARIES	4,715		35,921	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

STATE OF ILLINOIS

Page 12A

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721

Report Period Beginning:

1/1/02

Ending:

12/31/02

XI. OWNERSHIP COSTS (continued)**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37	Building			\$		\$	\$	\$	37
38	Ceramic Flooring	1996	107	5	20	5		37	38
39	Laundry Wall Protection	1996	1,109		5			1,109	39
40	Activity Room Remodel/Sink	1996	2,132		5			2,132	40
41	Laundry Doors	1996	1,874	125	15	125		854	41
42	Bathroom Sink	1996	678	34	20	34		235	42
43	Awning for Rehab Clinic	1996	983	98	10	98		664	43
44	Nurse Call System-Duplex	1996	770	77	10	77	0	520	44
45	Kemlite in Closets	1996	653	65	10	65		435	45
46	Power Access Door Operator	1996	1,009	101	10	101		673	46
47	Generator/Move to GSS	1996	3,431	343	10	343		2,287	47
48	Carpet for Parlor	1996	2,627		5			2,500	48
49	A/C-Roor Top on 200 wing	1996	229	15	15	15		99	49
50	Electric-Remodel Parlor	1996	186	9	20	9		61	50
51	Building-Remodel Parlor	1996	1,132	57	20	57		368	51
52	Plumbing-Remodel Parlor	1996	599	30	20	30		195	52
53	Carpet-Remodel Parlor	1996	1,164		5			1,107	53
54	Wallpaper-Remodel Parlor	1996	2,645		5			2,517	54
55	Shower Remodel-Grab Bars	1996	1,321	132	10	132		826	55
56	Carpet for Resident Room	1996	768		5			768	56
57	Replace Fixtures/Floor/Wall	1996	3,955	198	20	198		1,220	57
58	Windows	1996	25,212	1,681	15	1,681		10,365	58
59	Building-Remodel	1996	1,692	85	20	85		543	59
60	Wallpaper for Resident Room	1997	2,976	50	5	50		2,976	60
61	Window for Dining Room	1997	1,650	110	15	110		651	61
62	300 Wing Ceiling Tile Work	1997	2,584	43	5	43		2,584	62
63	Wall Built in Laundry Room	1997	1,013	101	10	101		600	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$ 1,403,282	\$ 49,667		\$ 49,667	\$ 0	\$ 1,045,079	70

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 1,403,282	\$ 49,667		\$ 49,667	\$ 0	\$ 1,045,079	1
2	Building continued								2
3	Wallpaper in Resident's Room	1997	3,838	64	6	64		3,838	3
4	Windows	1997	5,100	340	15	340		2,012	4
5	Carpet & Padding	1997	1,401	23	6	23		1,401	5
6	Wallpaper for Jack Andrews	1997	2,221	37	5	37		2,221	6
7	Carpet for Conference Room	1997	2,192	73	5	73		2,192	7
8	Conference Work Room	1997	1,350	135	10	135		799	8
9	Wall Protection	1997	739	25	5	25		739	9
10	New Sprinklers for Office	1997	909	91	10	91		515	10
11	Carpet	1997	768	64	6	64		768	11
12	Wallpaper-Resident Room #308	1997	2,667	222	5	222		2,667	12
13	Floorcovering and Labor	1997	975	81	5	81		975	13
14	Wallpaper for Offices	1997	782	65	5	65		782	14
15	Carpet for Resident Room	1997	506	42	5	42		506	15
16	Environmental Assessment of 61	1997	1,739	174	10	174		956	16
17	Roof-Front Entry	1997	21,178	1,059	20	1,059		6,265	17
18	Social Service & Conference Room	1997	1,392	93	15	93		510	18
19	D.O.N. & Staff Development Office	1997	1,236	82	15	82		453	19
20	Wallpaper-Room 308	1997	1,440	144	5	144		1,440	20
21	Drain/Sewer Work	1997	389	26	15	26		140	21
22	House 618 S Illinois Geneseo	1997	50,938	2,547	20	2,547		13,584	22
23	Floor Covering-Offices & Resid	1997	564	75	6	75		564	23
24	Ceiling Tiles	1997	1,390	232	6	232		1,390	24
25	Remodel Work in Room 309	1997	1,464	98	15	98		504	25
26	Siderail 1/2 Deluxe	1997	958	64	15	64		330	26
27	Siderails	1997	556	37	15	37		188	27
28	Drywall-Nurse Station	1997	625	115	5	115		625	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,510,599	\$ 55,675		\$ 55,675	\$ 0	\$ 1,091,443	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 1,510,599	\$ 55,675		\$ 55,675	\$ 0	\$ 1,091,443	1
2	Building continued								2
3	Rehab Wall Work	1997	414	76	5	76		414	3
4	Carpet	1997	1,396	256	5	256		1,396	4
5	Floorcovering & Labor-Apts	1997	1,832	336	5	336		1,832	5
6	Reroofing	1997	64,129	3,206	20	3,206		16,567	6
7	Building-Remodel Nurses Station	1998	18,510	740	25	740		3,702	7
8	Carpet-Remodel Nurses Station	1998	1,753	351	5	351		1,753	8
9	Wallcovering-Remodel Nurses Station	1998	1,794	357	5	357		1,794	9
10	Form & Pour Lamp Post Bases	1998	800	160	5	160		800	10
11	Floor Covering	1998	735	147	5	147		735	11
12	Apt Floor Covering	1998	573	115	5	115		573	12
13	Side Rails	1998	812	54	15	54		271	13
14	Kitchen Door	1998	1,242	83	15	83		393	14
15	Cabinetry & Installation	1998	3,799	190	20	190		902	15
16	Room 204 Work	1998	2,532	253	10	253		1,203	16
17	Vinyl Covering-Kick Plates	1998	1,367	137	10	137		564	17
18	Handrail & Installation	1998	699	47	15	47		222	18
19	Fire Alarm System Workr	1998	1,090	109	10	109		509	19
20	Bathroom Fixtures	1998	411	41	10	41		189	20
21	Roof Flashing Installation	1998	753	75	10	75		345	21
22	Koroguard in Med Room and Bath	1998	1,008	101	10	101		462	22
23	Carpet	1998	554	111	5	111		508	23
24	Generator	1998	47,534	2,377	20	2,377		11,289	24
25	Boiler Tank	1998	3,803	380	10	380		1,711	25
26	Door Frame Guards	1998	593	40	15	40		178	26
27	Water Heater & Labor	1998	1,339	134	10	134		592	27
28	Floor Covering Ceiling Tile	1998	1,397	280	5	280		1,211	28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 1,671,468	\$ 65,831		\$ 65,831	\$ 0	\$ 1,141,558	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12C, Carried Forward		\$ 1,671,468	\$ 65,831		\$ 65,831	\$ 0	\$ 1,141,558	1	
2									2	
3	Building continued									
4	Resident Room Work	1998	996	199	5	199		946		
5	Ceiling Tile	1998	20,524	1,025	20	1,025		4,447		
6	Project	1998	6,817	341	20	341		1,449		
7	Bathroom Work	1998	2,120	212	10	212		901		
8	Aluminum Entrance/Ambulance	1998	1,726	115	15	115		451		
9	Air Conditioning	1999	24,278	1,624	15	1,624		6,551		
10	HVAC Systems	1998	4,284	287	15	287		1,156		
11	Roof Work	1998	2,800	280	10	280		1,003		
12	House & Property	1999	86,726	2,168	40	2,168		7,047		
13	Wood Sign	1999	327	33	10	33		112		
14	HVAC	1999	2,350	234	10	234		842		
15	Plumbing-Bathroom Remodel	1999	4,739	237	20	237		869		
16	Building-Remodel Resident Room	1999	6,265	251	25	251		795		
17	Drapes-Remodel Resident Room	1999	279	56	5	56		177		
18	Electric-Remodel Resident Room	1999	197	10	20	10		31		
19	Paint-Remodel Resident Room	1999	2,697	539	5	539		1,708		
20	Thermostats for Apts	1999	1,412	94	15	94		259		
21	Faucets	2000	1,159	58	20	58		150		
22	Oak Cabinets for Kitchen	2000	1,603	107	15	107		294		
23	Laundry Repair	2000	533	106	5	106		293		
24	Building-Rental Prop Improvement	2000	19,696	787	25	787		2,035		
25	Carpet-Rental Prop Improvement	2000	60	12	5	12		31		
26	Generator Repair	2000	2,258	226	10	226		489		
27	Water Softener	2000	541	54	10	54		113		
28	Maintenance Garage	2000	80,708	5,314	15	5,314		8,430		
29	Bldg-Redecorate 300 Wing Corridor	2001	8,062	322	25	322		484		
30	Carpet-Redecorate 300 Corridor	2001	1,985	397	5	397		596		
31	Fire Alarm Control Panel	2001	414	41	10	41		55		
32	Work on Heat Units	2001	3,857	386	10	386		418		
33	Depreciated Items erroneously included within Nursing	2001								33
34	TOTAL (lines 1 thru 33)		\$ 1,960,881	\$ 81,346		\$ 81,346	\$ 0	\$ 1,183,690		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
1	Totals from Page 12D, Carried Forward		\$ 1,960,881	\$ 81,346		\$ 81,346	\$ 0	\$ 1,183,690		1
2	Building continued									2
3	Laminate Cabinets-Act.Room	2002	2,779	154	15	154		154		3
4	Phone Cable Wiring To Rooms	2002	700	47	10	47		47		4
5	Aire Conditioners-Building A	2002	6,175	515	10	515		515		5
6	Building - Remodel Resident Rms	2002	32,873	877		877		877		6
7	Caulking-Remodel Resident Rms	2002	193	13	10	13		13		7
8	Ceramic Tile-Remdl Resident Rm	2002	181	6	20	6		6		8
9	Corner Guard-Remdl Resident Rm	2002	90	6	10	6		6		9
10	Drapes-Remdl Resident Rm	2002	1,152	154	5	154		154		10
11	Drapery Rods-Remdl Resident Rm	2002	174	12	10	12		12		11
12	Wallpaper-Remdl Resident Rm	2002	1,809	241	5	241		241		12
13	Blinds-Remdl Resident Rm	2002	533	71	5	71		71		13
14	Carpet-Therapy	2002	622	21	5	21		21		14
15	Building-Redecorate	2002	11,912	159	25	159		159		15
16	Carpet-Therapy	2002	5,069	338	5	338		338		16
17	Corner Guards-Redec	2002	170	6	10	6		6		17
18	Doors-Redecorate	2002	199	4	15	4		4		18
19	Wallpaper-Redecorate	2002	1,905	127	5	127		127		19
20	House @ Congress St	2002	86,553	289	25	289		289		20
21	Furnace	2001	508	51	10	51		51		21
22										22
23										23
24										24
25										25
26										26
27										27
28										28
29										29
30										30
31										31
32										32
33										33
34	TOTAL (lines 1 thru 33)		\$ 2,114,478	\$ 84,437		\$ 84,437	\$ 0	\$ 1,186,781		34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$ 2,114,478	\$ 84,437		\$ 84,437	\$ 0	\$ 1,186,781	1
2	Land Improvements								2
3		1971-1975	19,636		15			19,734	3
4		1978	3,817		15			3,817	4
5		1981	5,292		15			5,246	5
6		1985	6,089		15			6,089	6
7		1988	62,030	4,135	15	4,135		58,239	7
8		1990	3,857		10			3,857	8
9		1991	11,223	561	20	561		6,313	9
10		1992	8,735	700	varies	700		7,855	10
11		1995	15,859	1,057	varies	1,057		7,666	11
12	Bury Elect Bury Electric Line	1996	3,347	335	10	335		2,315	12
13	Site Improvements-Duplexes	1996	50,912	5,091	10	5,091		32,668	13
14	Gazebo	1997	2,850	143	20	143		808	14
15	Walk	1997	2,500	167	15	167		944	15
16	Entrance Area Landscaping	1997	2,450	245	10	245		1,327	16
17	Sprinkler System	1997	727	48	15	48		146	17
18	Parking Lot	1997	2,265	113	20	113		595	18
19	Courthouse Research For Prepari	1998	515	52	10	52		253	19
20	Patio	1998	1,313	131	10	131		580	20
21	Skylight & Flashing work	1998	1,607	161	10	161		710	21
22	Sidewalk	1999	475	48	10	48		170	22
23	Blocks/Retension Pond	2001	1,128	56	20	56		75	23
24	0101 - 50% Nrsg	1999	13,797	690	20	690		2,185	24
25									25
26									26
27									27
28	Depreciated Items erroneously included within Nursing		(50,912)	(13,119)		(13,119)			28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 2,283,990	\$ 85,051		\$ 85,051	\$ 0	\$ 1,348,373	34

**Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 645,988	\$ 56,074	\$ 56,074	\$		\$ 380,241	71
72	Current Year Purchases	3,296	2,810	2,810			3,260	72
73	Fully Depreciated Assets	246,002					246,002	73
74								74
75	TOTALS	\$ 895,286	\$ 58,884	\$ 58,884	\$		\$ 629,503	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Truck		1994	\$ 3,000	\$	\$	\$	2	\$ 3,000	76
77	Rebuilding Truck		1996	3,596				4	3,596	77
78	19 passenger van	1998 Ford Eld	1998	46,636	7,773	7,773		6	36,920	78
79										79
80	TOTALS			\$ 53,232	\$ 7,773	\$ 7,773	\$		\$ 43,516	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 3,258,508	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 151,708	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 151,708	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 0	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 2,021,392	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87	Land	160,693			87
88	Building	2,600,386	78,433	473,291	88
89	Land Imp	67,120	1,888	26,671	89
90	FFE	88,687	4,637	58,282	90
91	TOTALS	\$ 2,916,886	\$ 84,958	\$ 558,244	91

G. Construction-in-Progress

	Description	Cost	
92	CIP	\$ 110,750	92
93			93
94			94
95		\$ 110,750	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? _____

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 4,220 Description: NETWORK COMPUTER EQUIP LEASE, ONE TIME RENTALS

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. /2003 \$ _____

13. /2004 \$ _____

14. /2005 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.	2. CLASSROOM PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> COMMUNITY COLLEGE <input type="checkbox"/> HOURS PER AIDE <u>94</u>	3. CLINICAL PORTION: IN-HOUSE PROGRAM <input checked="" type="checkbox"/> IN OTHER FACILITY <input type="checkbox"/> HOURS PER AIDE <u>41</u>
---	--	---

B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract		Total	
1	Community College Tuition	\$	\$	\$		\$	
2	Books and Supplies						
3	Classroom Wages (a)	2,256	2,256			4,512	
4	Clinical Wages (b)	984	984			1,968	
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests		150			150	
9	TOTALS	\$ 3,240	\$ 3,390	\$		\$ 6,630	
10	SUM OF line 9, col. 1 and 2 (e)	\$ 6,630					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	36
DROP-OUTS	
1. From this facility	3
2. From other facilities (f)	8
TOTAL TRAINED	50

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8		
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)		
			Units of Service	Cost	Units	Cost					
1	Licensed Occupational Therapist		hrs	\$ NOT APPLICABLE	\$		\$		\$	#VALUE!	1
2	Licensed Speech and Language Development Therapist		hrs								2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs								4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			\$		\$	\$		\$	#VALUE!	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 181,105	\$	1
2	Cash-Patient Deposits	6,923		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	436,680		3
4	Supply Inventory (priced at Cost)	9,886		4
5	Short-Term Investments	1,699,924		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	2,673		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 2,337,191	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	160,693		13
14	Buildings, at Historical Cost	4,714,863		14
15	Leasehold Improvements, at Historical Cost	273,747		15
16	Equipment, at Historical Cost	1,037,205		16
17	Accumulated Depreciation (book methods)	(2,579,636)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	32,892		21
22	Other Long-Term Assets (specify):	110,750		22
23	Other(specify): Asset Mgmt Purchases	10,642		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 3,761,156	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 6,098,347	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 50,456	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	247,130		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	174,436		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	48,821		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Security Deposits	21,430		36
37	Group Ins, Misc W/H Ganishments	(1,954)		37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 540,319	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Refd-Dplx Ent Fee, Non Refd-Dplx Fee	1,535,345		43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,535,345	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 2,075,664	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ 4,022,683	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 6,098,347	\$	48

*(See instructions.)

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 4,174,241	1
2	Restatements (describe):		2
3	35 - Congregate Living	16,461	3
4	40 - Apartments	9,418	4
5	45 - Duplexes	(32,604)	5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 4,167,516	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(60,450)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment	5,067	14
15	Other (describe) Dnr Rst Oper/Prop Gft-Cash	8,482	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (46,901)	17
	B. Transfers (Itemize):		
18	Cash Asset Assessmnt - CO	(97,931)	18
19	Rounding	(1)	19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$ (97,932)	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 4,022,683	24 *

* This must agree with page 17, line 47.

STATE OF ILLINOIS

Page 19

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE # 0004721

Report Period Beginning: 1/1/02

Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 3,131,165	1
2	Discounts and Allowances for all Levels	(308,474)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,822,691	3
B. Ancillary Revenue			
4	Day Care		4
5	Other Care for Outpatients	9,126	5
6	Therapy	161,888	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 171,014	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	872	12
13	Barber and Beauty Care	427	13
14	Non-Patient Meals	1,439	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	6,900	16
17	Sale of Drugs	30,615	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	11,836	19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 52,089	23
D. Non-Operating Revenue			
24	Contributions	9,661	24
25	Interest and Other Investment Income***	(57,911)	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ (48,250)	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>Nsg & Med Supplies</u>	19,428	28
28a	<u>Schd Attached</u>	5,607	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 25,035	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,022,579	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	722,703	31
32	Health Care	1,408,350	32
33	General Administration	740,820	33
B. Capital Expense			
34	Ownership	169,408	34
C. Ancillary Expense			
35	Special Cost Centers	2,409	35
36	Provider Participation Fee	39,339	36
D. Other Expenses (specify):			
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,083,029	40
41	Income before Income Taxes (line 30 minus line 40)**	(60,450)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (60,450)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE**# **0004721**Report Period Beginning: **1/1/02**

Ending:

12/31/02**XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)**

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,862	2,133	\$ 49,540	\$ 23.23	1
2	Assistant Director of Nursing	284	316	6,266	19.83	2
3	Registered Nurses	7,512	8,860	163,344	18.44	3
4	Licensed Practical Nurses	8,627	9,486	135,122	14.24	4
5	Nurse Aides & Orderlies	60,228	66,270	674,028	10.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	3,283	4,688	64,085	13.67	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,916	2,154	26,089	12.11	9
10	Activity Assistants	3,849	4,162	32,205	7.74	10
11	Social Service Workers	2,326	2,656	37,398	14.08	11
12	Dietician					12
13	Food Service Supervisor	1,981	2,132	27,517	12.91	13
14	Head Cook	5,353	6,050	65,109	10.76	14
15	Cook Helpers/Assistants	10,597	11,633	89,269	7.67	15
16	Dishwashers					16
17	Maintenance Workers	4,988	5,577	67,685	12.14	17
18	Housekeepers	8,772	9,866	86,332	8.75	18
19	Laundry	6,157	6,851	63,904	9.33	19
20	Administrator	1,579	1,788	45,033	25.19	20
21	Assistant Administrator					21
22	Other Administrative	2,381	2,516	39,361	15.64	22
23	Office Manager	1,654	1,831	23,233	12.69	23
24	Clerical	1,499	1,823	22,576	12.38	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,028	2,902	43,983	15.16	31
32	Other Health Care(specify)					32
33	Other(specify) <u>Purchasing&Res L</u>	1,544	1,682	22,761	13.53	33
34	TOTAL (lines 1 - 33)	138,420	155,376	\$ 1,784,840 *	\$ 11.49	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	147	\$ 6,656	Ln 1, Col 3	35
36	Medical Director		700	Ln 10, Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	2,719	32,952	Ln 10a, Col 3	40
41	Occupational Therapy Consultant	1,993	23,251	Ln 10a, Col 3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	312	1,744	Ln 10a, Col 3	43
44	Activity Consultant	25	1,373	Ln 11, Col 3	44
45	Social Service Consultant	30	1,635	Ln 12, Col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	5,226	\$ 68,311		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

Ending: 12/31/02

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT & LABOR	1/97	\$ 1,539	5	\$ 308	\$ 308	\$ 308	\$ 25	\$	\$	\$	\$	\$
2	PAINT	3/97	23	5	4	4	4	4					
3	PAINT	4/97	37	5	7	7	7	4					
4	PAINT	5/97	45	5	9	9	9	4					
5	PAINT	1/98	283	5	57	57	57	55					
6	WALLPAPER	3/98	362	5	72	72	72	72	20				
7	PAINT	4/98	343	5	69	69	69	69	22				
8	WALLPAPER/PAINT	5/98	723	5	145	145	145	145	60				
9	WALLPAPER/PAINT	6/98	38	5	15	15	15	15	11				
10	PAINT	7/98	65	5	13	13	13	13	6				
11	PAINT	8/98	361	5	72	72	72	72	43				
12	PAINT	10/98	75	5	15	15	15	15	11				
13	PAINT	12/98	864	5	173	173	173	173	158				
14	PAINT	2/99	1,800	5	300	360	360	360	360	60			
15	PAINT	3/99	4,032	5	605	806	806	806	806	203			
16	PAINT	4/99	97	5	13	19	19	19	19	8			
17	PAINT PT ROOM	7/99	44	5	4	9	9	9	9	4			
18	PAINT & LABOR	8/99	10	5	1	2	2	2	2	1			
19	PAINT	9/99	130	5	6	26	26	26	26	20			
20	TOTALS		\$ 10,871		\$ 1,888	\$ 2,181	\$ 2,181	\$ 1,888	\$ 1,553	\$ 296	\$	\$	\$

STATE OF ILLINOIS

Page 22

Facility Name & ID Number GENESEO GOOD SAMARITAN VILLAGE# 0004721

Report Period Beginning:

1/1/02

Ending:

12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).

(See instructions.)

1	2	3	4	5	6	7	8	9	10	11	12	13	
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT	11/99	34	5	1	7	7	7	7	5	\$	\$	\$
2	WALLPAPER	7/00	1,295	5		129	259	259	259	259	130		
3	WALLPAPER/PAINT	12/00	2,533	5		42	506	507	507	507	464		
4	PAINT	6/00	64	5		7	13	13	13	12	6		
5	PAINT	02/01	496	5			91	105	105	105	91		
6	PAINT	06/01	348	5			35	93	93	93	34		
7	PAINT	06/01	120	5			12	32	32	32	12		
8	PAINT	06/01	192	5			19	51	51	51	20		
9	PAINT	08/01	70	5			4	21	21	21	4		
10	PAINT	08/01	68	5			4	20	20	20	4		
11	PAINT	08/01	30	5			1	9	9	9	2		
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 5,250		\$ 1	\$ 185	\$ 951	\$ 1,117	\$ 1,117	\$ 1,114	\$ 767	\$	\$

Facility Name & ID Number **GENESEO GOOD SAMARITAN VILLAGE**

STATE OF ILLINOIS

0004721

Report Period Beginning:

1/1/02

Ending:

Page **23**

12/31/02

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? NO
- (2) Are there any dues to nursing home associations included on the cost report? NO
If YES, give association name and amount. _____
- (3) Did the nursing home make political contributions or payments to a political action organization? NO If YES, have these costs been properly adjusted out of the cost report? _____
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity? _____
- (5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 7,781 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease. _____
- (9) Are you presently operating under a sublease agreement? _____ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 39,339
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? YES
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ _____ Has any meal income been offset against related costs? YES Indicate the amount. \$ 1,439
- (16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. \$ _____
c. What percent of all travel expense relates to transportation of nurses and patients? 35%
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? YES
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. \$ _____
- (17) Has an audit been performed by an independent certified public accounting firm? YES
Firm Name: HENRY SCHOLTEN & COMPANY The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? YES If no, please explain. _____
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees.